SUPPLEMENT 1

For Federal criminal/civil case filing -- PETITIONER'S MOTION FOR REQUESTING PSYCHOLOGICAL/PSYCHIATRIC EVALUATION TO DETERMINE ACTUAL INNOCENCE FACTOR UNDER FALSE CONFESSION ELEMENT AND TO RESOLVE THE CONTROVERSY/CONFLICT BETWEEN GOVERNMENT AND PETITIONER OVER "DELUSIONAL DISORDER" –

Brian David Hill (Petitioner) v. United States of America (Respondent)

Criminal Case Number 1:13-cr-435-1
Civil Case Number 1:17-CV-1036

U.S.W.G.O.

USWGO Alternative News (USWGO.COM, DEFUNCT)
WE ARE CHANGE (WEARECHANGE.ORG)
INFOWARS.COM (THERE IS A WAR ON FOR YOUR MIND)
Oath Keepers (oathkeepers.org)
FederalJack (FederalJack.com)
Alternative Media/Truth Movement brigade

Lepage Associates
Solution-Based Psychological & Psychiatric Services
5842 Fayetteville Road #106
Durham, NC 27713
Telephone: (919) 572-0000
Fax: (919) 572-9999

LEPAGE ASSOCIATES FORENSIC EVALUATION SERVICES AND FEE AGREEMENT
(This form is for FORENSIC cases. If your evaluation will not be used in court, ask for another form.)

THIS FORM SPECIFIC TO EVALUATIONS IS AN ADJUNCT TO THE GENERAL MENTAL HEALTH SERVICES FORM. YOU MUST HAVE ALSO FILLED OUT THAT FORM WITH YOUR CONTACT INFORMATION. IF YOU HAVE NOT ALSO FILLED OUT AND SIGNED THE MENATL HEALTH SERVICE AGREEMENT, PLEASE ASK FOR THAT NOW. THANK YOU!

Regarding estimates of time: When an hourly fee applies instead of a flat fee, we will provide an estimate of the total number of hours the case will take and will track our time throughout; should the case take less time, we will return funds for hours unused, and should the case take additional time, we will require payment in full up front of an estimate of time remaining to complete the case.

Additional Time All other services not covered in flat fees above, including home visits, letters, email (reading and responding), telephone consultation (with yourself or others), etc., are billed at $200.00/hr.

Collateral Contacts Excessive collateral contacts and records reviews above norm in any evaluation above are extra and billed at $200.00 per hour. If you are concerned this may apply to you ask your evaluator and he or she will describe for you the typical amount of collaterals and records involved in each evaluation, so you can be clear what would increase your costs.

Regarding refunds: We do not offer refunds if you are unhappy with the evaluation, report, clinical suggestions or recommendations; we do not offer refunds if your insurance company refuses reimbursement of our services; we do not offer refunds under any circumstances.

Regarding settlement conferences, depositions and testimony: All evaluation fees include evaluation and report only, but do not cover giving depositions or testimony as a fact or expert witness, which are billed at $350.00 per hour. Travel time is $150.00 per hour. Entire fees must be paid in advance based on an estimate of time we will provide you with if subpoenaed. Settlement conferences $250.00 per hour. (There is an additional form that describes in detail our Testimony/Deposition Terms.)

Additional Fee Information: (1) If you are receiving a court-ordered evaluation, depositions and testimony may be part of the services we are asked to provide. Typically, it is the party subpoenaing the testimony who pays in full for witness services. Client payment must be in cashier's check. (2) If we are subpoenaed to provide case materials, time for your evaluator to go through the file and pull data is billed at $200.00 per hour; there is no additional charge per page for copies. However, please note most requests for documents cost between $100.00 to $200.00, as it takes 30-60 minutes to go through the file. (3) Please note you are solely responsible for payment of all collateral contacts we make on your case.

NOTICE OF EMAIL OF FINAL REPORT: It is our experience clients and/or attorneys like to receive an electronic copy of their report for their records, even though email cannot be guaranteed as a secure form of communication. Because this tends to be preferred, unless you tell your clinician you do not want the report sent via email, we will send your report via email. If you do NOT want your report emailed: (1) tell your clinician directly and (2) CROSS OUT the lines on Page 3 about email.

TAPE RECORDING AT ANY TIME IS NOT ALLOWED.
By signing below, you swear you are not tape recording.

Copying and Returning of Materials Provided to Us: **Please do not give us originals of any materials. We do not make copies of materials provided to us for yourself, your attorney, or the other side, and we do not return any materials provided to us.** We are not a photocopy facility; should you desire copies of materials one another provided, you need to get those from each other or from the original source. Our report will list the original source of all information so that parties can be clear where to locate information, if parties did not already agree in advance to make copies of materials provided to us for one another as well. If you did not have such an agreement in place and you desire copies, you must go to the original source for this information, or you and the other party could agree to provide to one another's attorneys all information you each provided to your evaluator.

Confidentiality: **Principles of confidentiality and privilege do not apply within the context of a court-ordered evaluation; the privacy of information is not protected under federal medical privacy law. There is no confidentiality in a court-ordered evaluation.** Information is subject to re-disclosure by a recipient of such information, and your evaluator will regularly disclose what is said or presented by all parties, collateral contacts, children, etc., when asking follow-up questions of others, and observations and test results will also be disclosed in the report. Information may be disclosed to the court or attorneys during legal action related to the evaluation. Information concerning your payments is also not confidential, and both sides can be given a complete accounting of all payments made by both parties and any amounts owed. Also, your evaluator is required by law to report allegations of abuse or neglect, and this reporting must not be interpreted as a display of support for the individual who made the allegations or against the person being accused, or as an indication that the evaluator finds the allegations credible. Records will not be released without a court order or the client's consent.

Necessity for Structured Contacts: **In the interests of a balanced evaluation and expediency, during the evaluation your contact with the evaluator is limited to the structured interviews and contacts included in the evaluation. To clarify, you are not to email or phone the evaluator** other than to schedule or cancel appointments, unless the evaluator has specifically asked you to provide information via email or phone (such as an evaluator-initiated follow-up interview or an evaluator-requested email).

Evaluation Feedback and End of Contact: If requested we will provide one 30-45-minute verbal feedback session either in-person or via telephone, mode chosen by evaluator; these feedback sessions are included in the flat fees but are billed separately when we are doing hourly consults. **That will conclude in its entirety the scope of our ability to provide feedback regarding the report.** However, we do agree to be hired to attend settlement conferences, and/or provide deposition or testimony if needed.

FORMAT FOR PROVIDING RECORDS: (1) We must be provided with a hard copy and an electronic copy of all records. We will not review records unless we have been provided e-copies and hard copies formatted as described herein. (2) The electronic copy of records can be sent as individual attached records for up to five records; more than five records must be attached as one zip file. (3) Hard copies of over five records must be neatly organized in a binder, and tabbed using the headings listed in #4 herein. (4) A typed list of what is being provided must be included using these headings: Legal Records; Medical Records; Mental Health Records; School Records; Texts and Emails; Photos/Audio/Video. (You may add other headings as needed.) This list must be in a Word document in the e-copy, so we may cut and paste the list of what you provided into the final report; thus, this list should not include any commentary about items provided. List should include for each item the professional entity and specific clinician as applies, date(s) of records, and brief description if needed. Here are some examples:
UNC Pediatrics, John Doe's medical record (02/04/2013-04/02/2015)
Barbara Lowe, Ph.D., therapy session notes for Jane Doe (1/4/17-11/10/17)
East Chapel Hill High School, Julie Doe's report cards (7/21/2016-3/16/2017)
Text Messages between John Doe and Jane Doe (dated 08/10/2014 to 10/09/2016)

PLEASE BE SURE TO SIGN PAGE 3 AND FILL IN ALL INFORMATION.
KEEP PAGES 1-2 FOR YOUR INFORMATION, AND RETURN PAGE 3 TO US.

Referral Question (What do you hope to learn through evaluation?): _____

_____

Was the evaluation ordered by the court? YES NO (If yes, list county: _____)

Please circle to indicate type of evaluation (ask for help if you are not sure):

Expanded Psychological Evaluation: $1,995.00
(to include psychological + substance abuse)
DUI or citation letter: $175.00

Psychological Evaluation: $1,495.00
Full Battery: $2,550.00
MMPI-2: $250.00 (feedback session $80.00)

Parental Capacity: $3,000.00

Custody Evaluation: This is the wrong form

Immigration: $300 / $400 / $800 / $1,000
Malingering Eval (mental health): $1,495.00
Competency to Stand Trial: $1,495.00 -or- $2,550.00
Malingering Eval (cognitive): $1,995.00
Mitigation/Diminished Capacity or Insanity: $1,495.00
Sex Offender: $1,495 to 2,250.00 depending on case details and records to review
Risk Assessments: Standard RA: $1,695.00 Expanded RA: $2,250.00 Full Battery RA: $2,950.00

Other testing: $200.00 per hour

Test(s): _____

Estimated time: _____

_____

– OR – flat fee quoted at: _____

_____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS DOCUMENT AND THE MENTAL HEALTH SERVICE AND FEE AGREEMENT, AND AGREE TO ABIDE BY THEIR TERMS DURING OUR PROFESSIONAL RELATIONSHIP.

In particular, please note the following important statements:

·Payment as described above is due up front; the evaluation will not begin until payment is received.
·If for any reason payment in full has not been made, the report will not be released until payment in full is made. This is standard practice in our field for evaluations and there are no exceptions to this policy; no report will be released under any circumstances until payment in full has been made.
·Should you subpoena us and not pay our full estimate in advance as agreed, our attorney will become involved and you agree to be responsible for 100% of our attorney's fees, said fees to be rolled into your estimate due.
·The full fee is charged for missed or cancelled sessions, unless you cancel 48 hours in advance.
·We do not offer refunds under any circumstances.
·Fees apply for bounced checks: amount due + 10% late fee, our collateral time to rectify at $200/hour, plus any and all fees of outside services used to collect the debt. $25.00 fee per declined credit card payment.
·By signing below you ask and agree to receive your evaluation via email and understand the risks.

Please sign and date below to indicate that you have read the preceding information in full, and understand the information. Please ask for clarification of any information you are unclear about
I have read and understand the Lepage Associates Forensic Evaluation Services and Fee Agreement. I agree to the statements herein and the terms of payment and emailing of the report.

_____ _____

Print ***PATIENT NAME*** Legibly
If patient is a child, print parent name here.
*If a child is receiving the evaluation, child is the patient, NOT the parent.

_____ _____

Signature of Patient, or of Parent if Patient is a Minor
Date

WELCOME!

We look forward to working with you.

It is very important for us to know how you first heard about Lepage Associates. We appreciate you taking a minute to fill out information about how you found us. THANK YOU!

YOUR NAME: _____ TODAY'S DATE: _____

Referral Source: Please indicate how you heard of Lepage Associates by placing a check in the box, and filling in any additional information asked for.

[ ] 1. Professional Referral or Colleague (Please write *full name and complete work place information* for person. If the professional was a Lepage Associates clinician who you met, please indicate where you met them, for example, giving a public Seminar, at a group, etc.)

_____

_____

[ ] 2. Friend/Family/Personal/Previous Lepage Client (Please circle which of 4 applies.)

[ ] 3. Lepage Associates Website (How did you find or link to us? Please indicate below.)

3a. I linked to you from another site (circle site): Psychology Today Theravive Good Therapy Psychotherapy Resources Therapy Tribe Separating Together Solutions for Separating Better chapelboro.com-Parenting Page column Chapel Hill Mother's Club-Ask Anything column

3b. Someone gave me your website address **(Who? If a professional, please fill in #1 above.)**

3c. Internet Search **(What wording did you search?)** _____

[ ] 4. Social Media (Please circle) Facebook Twitter LinkedIn Google+

[ ] 5. Flier or Brochure (Where did you find this?) _____

[ ] 6. Hard Copy Newspaper or Magazine (Please circle) Carolina Parent Southern Neighbor On the Record Other Paper or Magazine: _____

[ ] Other (Please explain) _____

_____

[ ] *I'm sorry, I can't recall*

FOR OFFICE USE ONLY – REFERRAL FORM REVIEWED BY: _____

Lepage Associates
Solution-Based Psychological & Psychiatric Services
With offices in S. Durham/RTP,
Raleigh and Chapel Hill
Main Telephone: (919) 572-0000
www.lepageassociates.com

LEPAGE ASSOCIATES MENTAL HEALTH SERVICE AND FEE AGREEMENT
Information Concerning the Practice, Financial Arrangements, Confidentiality and Patients' Rights
Thank you for the opportunity to offer our professional help to you. We have prepared this form to describe our professional services and office procedures. Please ask questions if you need clarification.

Services & Staff Qualifications: We provide mental health services to adults, adolescents, children, groups, couples and families. Services include: therapy for individuals, groups, couples and families; play therapy for children; psychiatry; educational and psychological evaluations; forensic evaluations; and consultation. **We do not provide emergency services**, though your clinician will attempt to be available to you as soon as possible should a crisis occur. We strive to provide the highest quality mental health services available. All clinicians hold doctorate degrees in psychology, are MDs, or have a master's in psychology or social work plus 10+ years of experience. All are also licensed to practice in NC; or are completing their licensure hours under the supervision of a licensed clinician. (At times, we may also have doctoral students in training.) This contract is between you and your service provider, not between you and Lepage Associates, or any other member of the practice. Due to the nature of psychological services, your provider is solely responsible for determining the method, details and means of performing services and is solely responsible for his/her clinical and non-clinical work, regardless of whether or not he/she has discussed the case with Dr. Lepage and/or other staff or engaged in outside peer review. We do not offer refunds if you are unhappy with the sessions, any written summary, clinical suggestions or recommendations, etc; or if insurance does not reimburse you; we do not offer refunds for any reason.

Schedule of Fees: (1) Intake: $185.00 (intakes vary in time). (2) Individual, Couples, or Family Therapy Appointment 45 minutes: $150.00; 60 minutes: $185.00; 75 minutes: $225.00. (3) Group Therapy & Seminars 75 minutes: $80.00. **Please note appointment time is approximate and may vary slightly.** (4) Therapy, non-forensic consults and collateral services with Dr. Tina Lepage: $250.00 per hour. (5) Career Counseling: $595.00 for testing + 1 pre and and 1 post testing session; other career counseling sessions charged at regular individual therapy rates. (6) Evaluation: Educational, psychological, custody, and forensic evaluations provided. If you are having an evaluation, we will provide you a separate form with descriptions of what evaluations involve and the cost. (7) All other collateral services, including phone calls, letters, email (reading or responding), and telephone consultation (psychiatrists, physicians, teachers, guidance counselors, attorneys, etc.) are billed at $150.00 per hour. Meetings attended in your behalf are also billed at $150.00 per hour; $150/hr travel time. (8) Depositions and testimony as fact or expert witness $350.00 per hour time preparing for and giving deposition, and port to port fees $150.00 per hour; due in full in advance based on estimate of time. Fee Schedule Psychiatry Services: (1) Intake: $385.00 ages 18+ (up to 60 minutes), $450.00 child (up to 90 minutes); Medication Management $185.00 all ages (up to 20-25 minutes); and MD Therapy or 45/50-minute med mgmt. $285.00 all ages. (2) Medication Refill (i.e., call to refill outside of normal in-office session): $25.00 with 7 days' notice, $75 with less than 7 days' notice. (3) Collateral services: $285.00 per hour. Other Fees: (1) Late Fees/ Credit & Debit Card Declines/Returned Checks: For therapy and psychiatry, if you do not pay in full on the date services are rendered, 10% of the original charge will be added *each week* you are late, and for evaluations 10% of the total original charge will be charged one time. A $25.00 fee is charged for any credit or debit card decline. Regarding returned checks, you owe any fees the bank charges us, any fees for time we must spend talking with the bank or yourself to rectify the situation (billed at $150/hr), + any late fees that apply. Regarding delinquent accounts, you are responsible for in full and will be charged for in full all time we spend trying to collect on the account (billed at $150/hr), and/or all fees of any outside services, such as an attorney or credit collector, hired to collect the debt. (2) No show/late cancel: full fee.

Please See Reverse →

Insurance/Payment: As clinicians, our relationship is with you and not your insurance company. If you wish, we will assist you in understanding your insurance benefits for mental health services by contacting your insurer, to inquire about your benefits. We will also be happy to help you process your insurance claims for reimbursement. It is your responsibility, should you desire reimbursement to yourself, to process the claim with your insurance provider or to ask us for help. **All charges are your responsibility from the date services are rendered, and payment for services is due in full on the date services are rendered.** Payment in full will be collected at the beginning of each session. **We accept credit cards.**
MEDICARE: Note we have opted out of Medicare, and our services cannot be reimbursed by Medicare.
TRICARE: You must disclose if you have Tricare insurance as the government requires providers to accept a reduced fee for Tricare, and as such we need to determine up front if we have space for a reduced fee case at this time. Our clinicians try to accommodate as many reduced fee cases as possible, but we may not always have room for another reduced fee case.
Cancellations and Rescheduling: **Clients are most successful utilizing therapy when they find a way to make it a priority.** The full fee is charged for therapy/psychiatry appointments missed or cancelled less than 24 hours in advance, and group therapy or evaluation less than 48 hours in advance. No charge will be made if (1) you are ill, (2) you have an emergency, or (3) we are able to reschedule you for an alternative time within the same M-SAT week. STORM POLICY: If driving conditions are hazardous due to weather, we will keep your same appointment time and provide therapy via phone, Skype or FaceTime (or you may opt to cancel without penalty, but we encourage you to keep your appointment).
Confidentiality & Patients' Rights: Confidentiality is your expectation that the information you disclose to us will be kept private, including the fact that you consult with us at all. **Please note that we do discuss cases internally at Lepage Associates in peer supervision, and by signing you give permission for these discussions.** As a general rule, outside of peer supervision, we will not disclose information regarding a patient unless authorized to do so by the patient in writing. One exception to this is if we employ outside services to collect past due accounts; by signing below you give permission for such disclosure if necessary. **There are also legal exceptions to confidentiality; these are described in our Notice of Privacy Practices, The Health Insurance Portability and Accountability Act.** HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations. The law requires we obtain your signature acknowledging we have provided you with this information; **by signing below you are certifying that you have been offered this Notice and given a copy of the Notice if you want**. You may revoke this Agreement in writing and that will be binding on us unless: we have taken action in reliance on it; if there are obligations imposed on Lepage Associates by your health insurer in order to process or substantiate claims; or if you have not satisfied any financial obligations.
Children & Treatment Consent: To provide consent for treatment for a child you must either have sole legal custody OR shared legal custody OR legal guardianship. **By signing below, you are stating you have the legal right to consent for this child.** (If you are divorced and share legal custody and your divorce agreement notes you must inform the other parent of health appointments, our services fall under this, and you may be in violation of a court order if you fail to inform the other parent of our services with your child. **If you share legal custody, by signing below you are stating you have told the other parent, or will tell the other parent expeditiously, you have brought the child to us for services.**)
Contacting Your Clinician: While we are usually in the office, we cannot take calls when we are with a client. When unavailable, our phone is answered by a receptionist or voice mail we monitor frequently. We will make every effort to return your call on the same day, or at least within 24 hours, with the exception of weekends and holidays. **Email is not a secure form of communication and confidentiality cannot be guaranteed.** We may initiate email regarding non-clinical issues such as scheduling, and by signing this form you agree to that communication. We also may respond via email should *you choose* to email us regarding any issue, and by signing this form you understand by initiating email you agree to its use by us in response to you. Similarly, we may email you if you leave a message asking us to email.
In Case of An Emergency: We do not provide emergency services. In an emergency, you should: contact your primary care physician, go to the nearest hospital emergency room and ask to speak with the psychiatrist on call, and/or follow your insurance carrier's emergency procedures.

PLEASE BE SURE TO FILL IN ALL INFORMATION ON PAGES 1, 4 & 5. THANK YOU.
(KEEP PAGES 2 & 3 FOR YOURSELF AND TURN IN PAGES 1, 4 & 5 TO US.)

Please sign below to indicate that you have read the preceding information in full and understand the information. Please ask for clarification of any information you are unclear about. YOUR SIGNATURE INDICATES THAT YOU HAVE READ THIS DOCUMENT AND AGREE TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP. **I have read and understand the Service and Fee Agreement. I agree to the statements herein and terms of payment, to include payment of all fees listed. If minor patient, I certify I have the legal right to consent treatment for the minor.**

Print ***PATIENT NAME*** Legibly

For couple's only, 2nd name here

*If a child is receiving care, the child's name goes here, NOT the parent's name.
*If a couple is receiving care, please list as Patient Name the person with insurance. (This is for your convenience so the Receipt we provide you will be structured correctly for you to turn in for insurance.)

Social Security Number of ***PATIENT***

Date of Birth of ***PATIENT***

Signature of Patient, or of Parent if Patient is a Minor

Date

(If parent signs, please also print parent name legibly beside parent signature.)

For couple's only, Social Security of 2nd name

For couple's only, Date of Birth of 2nd name

For couple's only, Signature of 2nd Name

Date

Contact Information: Please fill in the following required information.

PATIENT

Mailing Address

City, State and Zip Code

Cell Phone Number / Work Telephone Number

Home Telephone

Email Address

FOR COUPLE'S ONLY, 2nd PERSON

Mailing Address

City, State and Zip Code

Cell Phone Number / Work Telephone

Home Telephone

Email Address

DO YOU HAVE MEDICARE – or – TRICARE? [ ] YES [ ] NO
If you have Medicare, there is a separate form you must fill out in addition. Please ask the receptionist for the Medicare form. If you have Tricare, you must disclose this to us. Thank you.

LEPAGE ASSOCIATES NEWSLETTER: Our newsletter is designed to keep the community abreast of new information in the field. A typical newsletter might include articles on topics in health and helpful links to other sites with resources. It is sent every other month as a useful resource for our clients and other professionals. Your email address is completely confidential and hidden when the newsletter is sent. We *never* provide your email address to anyone else, and you can easily Unsubscribe at any time. We have gotten very positive feedback on the newsletter and hope you will enjoy receiving it. By signing above you give permission for us to send this; of course you can Unsubscribe at any time.

Payment of Services by Debit Card or Credit Card:

For your convenience, we accept payment via debit or credit card; you should bring your card to each appointment for us to swipe. You may also pay on the day of your appointment with check or cash. **We require you keep a card on file to cover any unpaid balances** (unpaid balances are rare; an example might be if you didn't have your credit card or checkbook with you to pay). **This also ensures you will never have to pay late fees**, as if you owe a balance we will charge it before late fees would be assessed. Please complete the following information. BY SIGNATURE BELOW YOU AUTHORIZE LEPAGE ASSOCIATES TO CHARGE YOUR CREDIT CARD IN THE AMOUNT INDICATED ABOVE ON PAGE 2 SECTION "SCHEDULE OF FEES," ANY TIME YOU OWE A BALANCE.

We accept: VISA MasterCard DISCOVER FINANCIAL SERVICES

CREDIT CARD NUMBER _____

CVV NUMBER _____ EXPIRATION DATE _____

NAME AS SHOWN ON CARD _____

CARD BILLING ADDRESS _____

_____

_____ _____

CARDHOLDER SIGNATURE DATE

FOR OFFICE USE ONLY – INTAKE FORM REVIEWED BY: _____